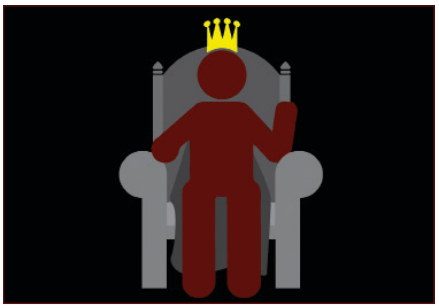

The Very Important Patient

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EDITOR'S NOTE

The patient cases presented in Psychotherapy Rounds are composite cases written to illustrate certain diagnostic characteristics and to instruct on treatment techniques. The composite cases are not real patients in treatment. Any resemblance to a real patient is purely coincidental.

ABSTRACT

The Very Important Patient poses specific challenges to the treating psychiatrist. Whether it is fame, money, power or position that creates the VIP status, this type of patient can elicit similar feelings within the psychiatrist and create various treatment barriers. Boundary violations, accompanying entourage, presentation of gifts, devaluation, scheduling irregularities and transference/countertransference issues are some of the concerns that may arise within the psychiatric treatment of the VIP patient. This article will review the treatment dynamics created by the VIP patient as well as the approaches that the psychiatrist can utilize in a therapeutic manner.

KEYWORDS: VIP patient, difficult patient, influential patient, entitled patient, physician patient, countertransference

Psychiatrists are often faced with "very important patients" (VIPs) who have more power or prestige than a typical patient or who behave as though they deserve special treatment. These patients can produce unique diagnostic, therapeutic, and practical challenges. Groves et al[1] described three categories of VIPs in the context of psychotherapy: celebrities, wealthy and/or influential people, and potentates. The first two categories describe patients who have more intrinsic power in the relationship than typical patients, and the last category describes patients who believe themselves to be well-connected and deserving of special treatment.[1] This latter category of patients fits well within the psychiatric framework of narcissistic personality disorder (NPD).[2]

The VIP can induce many reactions in the treating psychiatrist: excitement to treat someone important, flattery at being chosen to participate in the VIP's personal care, fear of being discovered as inadequate, and/or anger and/or resentment against the patient for causing disruption in the normal flow of treatment. There is significant overlap between treating VIPs and treating "difficult" patients. Difficult patients often include those who have negative attitudes toward their psychiatrist and treatment teams, and therapy can be challenging.[3] While the VIP might not hold negative attitudes toward the treating psychiatrist, the individuals who intercede on behalf of the VIP might create undue pressure for the psychiatrist.[4] Treatment cases with VIPs are often fraught with expected or demanded exceptions to the rules from the beginning by the patient and/or his or her entourage, and adherence to standard protocols of care can feel unusual to the psychiatrist and staff.[5]

THE CELEBRITY PATIENT

Case vignette. *Dr. A received an urgent message from her hospital's chief executive officer that a famous musician's team had reached out to the hospital for the musician's mental health treatment. Dr. A called the number given for the musician—Ms. B—and spoke to her assistant. The assistant offered a very limited list of appointment times that Ms. B would be available to meet with Dr. A, with the clear expectation that Dr. A should accommodate Ms. B's schedule. Coincidentally, Dr. A was able to meet at one of the times requested.*

Ms. B presented to Dr. A's office with a coterie of three others for her first appointment, one of which was observed filling out the intake paperwork for the patient. When Ms. B was called into the psychiatrist's office from the waiting room, the people accompanying her also rose to their feet as though to join Ms B for her treatment session with the psychiatrist.

"Thank you, but I'll need to see Ms. B alone first," Dr. A said to the group with Ms. B.

PRACTICE POINT: Set and maintain the therapeutic framework to minimize disruption to care protocol. This vignette illustrates the potentially disruptive nature of treating high-profile individuals, who might have their own staff complete tasks that a typical patient would do for him or herself, like scheduling an appointment or filling out paperwork. Dr. A set appropriate boundaries and began the treatment as though Ms. B were any other patient.[6] Managing irregularities surrounding the initiation of therapy was difficult, but allowed for the safeguarding of the therapeutic frame and set the tone for the continuation of the therapy. This also underlined privacy as a central tenant to developing a strong therapeutic alliance, which is especially

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important when treating famous patients.[7]

Case vignette, continued. *As Dr. A brought Ms. B back to the office, Ms. B obviously took stock of the furnishings, but said nothing.*

"You probably saw on Twitter why I'm here," she said.

"Actually, I'm not quite sure," said Dr. A. "It might help our time together if you assume that I don't know anything about you."

Ms. B reported that she had been struggling with depressed mood and a creative block since a public breakup with her significant other.

"I don't know if you can help me," she told Dr. A.

Dr. A worked to maintain a neutral stance in cultivating a therapeutic alliance without giving in to the desperate feeling of scrambling to make this influential person like her.

"I don't know if I can either," said Dr. A, "but I'd like us to work together to help you make sense of this." Dr. A then reviewed the intake paperwork and expectations for therapy with Ms. B, and they concluded their first session.

Before her next appointment with Dr. A, Ms. B arranged to have new furniture sent to the office. Dr. A had been intending to update the waiting room, and her office staff was thrilled with the new lamps, tables, and chairs; however, Dr. A declined the delivery. At their next appointment, Ms. B expressed disappointment to the psychiatrist that the new furniture was not in the office.

"You really need new furniture," Ms. B told Dr. A. "I was only trying to help. I can't even do this right!" she exclaimed, and then started crying.

Dr. A reassured her that it was thoughtful, but that she could not accept the gift because it was too generous.

Ms. B said, "I just can't tell about things like that anymore. What's too cheap for people around me now is way too fancy for all the other people in my life."

Ms. B described her feelings of isolation from both her communities—her industry acquaintances, who were well-connected and wealthy, and her family and previous social circle, who were part of the working class.

PRACTICE POINT: Set boundaries and practice medicine equally for all patients. As with all psychotherapy patients, gifts are an important subject to be discussed in therapy.[9] When Dr. A was able to reinforce the therapeutic boundary that gifts were not necessary for treatment, it allowed Ms. B to explore how adrift and unmoored she felt in her current environment. When refusal of a gift is thought to be more hurtful and damaging to the therapeutic relationship than accepting it, careful discussion of the motivation, intent, and meaning with the patient allows for the ethical delivery of care.[10]

Dr. A demonstrated another recommendation in treating the prestigious patient—practice medicine the same way for all patients.[8] While this obviously can be difficult, creating a nonjudgmental, neutral environment allows for a space free from the expectations of others. Adherence to treatment as usual, regardless of a patient's social status, is a solid guiding principle.[11]

Dr. A also worked with her staff to contain their initial excitement over the new furniture and then their disappointment when it was returned. She noted that her staff was being much more courteous to her since the famous singer had begun treatment, and she discussed with them that Ms. B should be treated in the same manner as any other patient. Dr. A then took this opportunity to reinforce the clinic's privacy policies regarding patients.

THE WEALTHY AND/OR INFLUENTIAL PATIENT

Case vignette. *Mr. C, a wealthy real estate developer and philanthropist, was initially referred to Dr. A by the chief medical officer (CMO) of Dr. A's hospital system for treatment after being served divorce papers.*

"I don't know why she's leaving me," Mr. C told the psychiatrist. "She'll never have it as easy as she had it with me. I paid for everything: her clothes, the kids' school, spin classes, hot yoga. All women just want money."

"All women?" Dr. A asked.

"Yes, all women," replied Mr. C. "You are more than glad to take my payment!"

Dr. A laughed and conceded the point. "Well, I guess it's true," she said. "I do take your payment."

Mr. C chuckled, saying, "Well, you've been fair with me here," and then, more seriously, "but I've worked hard and sacrificed for my family, and I thought she would appreciate the money when we were together, but I don't think it was enough."

Dr. A replied, "It sounds difficult to experience the feeling that someone has taken advantage of you."

PRACTICE POINT: Stay grounded and empathic. Dr. A initially struggled with having this angry, well-connected man in her office, and found herself siding with Mr. C's wife at times. However, Dr. A grounded herself by recalling what she liked about Mr. C—that he was honest and that he worked with underprivileged families. Dr. A was also able to tolerate Mr. C's harsh words, hear his pain, and then connect with him through humor and by acknowledging that pain. Mr. C might not have responded well to treatment if Dr. A had not been able to access her empathy.

Case vignette, continued. *Later, Mr. C's assistant called Dr. A to say that Mr. C would not be able to attend their next appointment because he would be meeting his friend, who happened to be the CMO of the hospital and Dr. A's boss. Mr. C's assistant then relayed the patient's request that she wait for him outside the CMO's office so that they could meet with each other then, as soon as he was done meeting with the CMO. Dr. A called Mr. C back and left a message saying she would not be able to meet him outside her CMO's office. She offered other appointment times, and Mr. C's assistant later confirmed that Mr. C would be able to attend his original appointment time in her office. During the next appointment, Dr. A addressed this with Mr. C, politely informing him that her office was the only place where therapy would take place.*

He laughed. "Oh, lighten up!" he said, with a dismissive wave of his hand.

Dr. A found herself feeling threatened by Mr. C's apparent closeness with her boss and insulted by his overly familiar demeanor and apparent lack of respect for her time and space. She worked with her own supervision group to manage her countertransference feelings of inadequacy, fear of retribution, and anger.

PRACTICE POINT: Maintain a balance of power in the psychotherapy context and adhere to practice protocol. Like a celebrity, influential patients can wield more power over the physician than a typical patient. In addition to the changed power dynamic, influential patients can also cause administrators and clinical supervisors to behave differently. Maintaining the power balance in the therapeutic context is helpful in asserting oneself as the person in charge of the psychotherapy, allowing the psychiatrist to remain confident in his or her medical skills and judgment, as well as to command the medical aspects of the case.[8]

Caring for VIPs can additionally create a pressure to change typical best practice habits, but resisting these pressures honors the guidelines of psychotherapy that demand careful, curious examination of the context in which a patient finds him or herself.[12] Administrators might ask for preferential treatment, such as

immediate, informal phone consultations or shifting appointment times or locations to allow a wealthy donor to be seen more quickly. Clinical supervisors might encourage treatment that does not follow the standard of care to meet the expectation of immediate recovery by the VIP. Adherence to the therapeutic frame, regardless of the patient, is a basic tenant of psychotherapy[13] and will assist the psychiatrist in containing emotions and behaviors that are not therapeutic.

PRACTICE POINT: Transference/countertransference with VIPs. Transference is the sum of the feelings, both conscious and unconscious, that the patient has toward the psychiatrist.[18] These past experiences can result in "transfer" of either positive or negative emotions or behaviors onto the present therapeutic relationship. The VIP might have the unrealistic expectation that the psychiatrist will treat the patient with a higher regard, similar to how others treat the VIP. Another transference reaction might include acting like a peer.[19] The patient might have a fantasy about being healthy and might not accept the patient role, consequently treating the psychiatrist like a friend.

Similarly, countertransference is the sum of the feelings or emotions the psychiatrist has about the patient.[18] Countertransference is especially significant within the therapeutic relationship when the patient is a VIP. Murray et al[16] identified three possible forms of countertransference that can potentially occur when treating a VIP. VIPs might engender a mirroring countertransference within the psychiatrist. The psychiatrist might become concerned with being "liked" or feel pressure to please the VIP, or the psychiatrist might be overly accommodating and engage in boundary-crossing violations that would not occur with other patients.[20] The patient's VIP status might trigger a loss of objectivity that the psychiatrist would provide to any other patient.[4] The psychiatrist might fear professional rejection or legal retribution. Prior experiences might cause the psychiatrist to feel worried about how the patient might perceive his or her medical expertise, and such feelings might be magnified in a VIP.[20]

An idealizing countertransference, in which the physician idealizes the VIP,[16] can cause the physician to avoid aspects of the patient's history. The physician might unconsciously be hesitant to ask certain questions or make specific interpretations, such as abuse history or drug and alcohol use. Furthermore, the physician might misinterpret the patient's therapeutic dialogue in an unconscious attempt to maintain the idealization.

Finally, the VIP can create a countertransference within the psychiatrist that is associated with dichotomous thinking. The physician might experience the simultaneous desire to rescue the VIP and the dread of failing the VIP, leading the physician to strive for unachievable outcomes.[16] Consultation with a trusted colleague can help the psychiatrist in this situation. Peers outside of the clinical situation can offer alternative interpretations of events and/or discussion of similar patients and can allow for the diffusion of hostile or angry feelings that can undermine clinical care.[5]

Though these feelings are likely unconscious, identification of the countertransference early in treatment could prove to beneficial. Realizing that the psychiatrist is deviating from the standard of care can bring the countertransference issues to awareness. The psychiatrist can review best-practice guidelines both early and throughout the treatment of a VIP patient. This can provide reassurance to the psychiatrist and bring awareness to any deviations that might occur.[16]

THE POTENTATE PATIENT

Case vignette. *Dr. E was referred to Dr. A's office at the request of his residency training director. Dr. E was the chief resident in his residency program, but he had been administratively reprimanded for various conflicts with nursing staff and other residents. His residency training director had mandated that he seek psychotherapy if he wished to continue in his training.*

PRACTICE POINT: Maintain objectivity when treating another physician. Any physician patient can be considered a VIP because their presumed knowledge or position can influence the judgment of the treating physician.[4] The treating physician might feel conflicted or ambivalent in playing the role as both a colleague and as a physician. The treating physician might order unnecessary tests or avoid testing all together. The treating physician might also prescribe treatments that could be considered either too conservative or too progressive compared to the standard of care.[21] Additionally, when a physician is treating another physician, he or she might assume that the physician patient understands or knows what the treating physician does, even if the specialties of the two physicians differ. The treating physician might mistakenly accept the patient's opinion because of this assumption.[4] This can create blurred lines in the therapeutic alliance, causing a shift in the balance of medical authority. Furthermore, physician patient might require additional reassurance compared to other patients because of the uncertainty that comes with his or her additional knowledge and experience.[22]

It can also be common for the treating physician to identify with the physician patient. The treating physician might see the physician patient as a mirror of him- or herself and might wonder what led the patient to this state.[19] The treating physician might fear being diagnosed with the same condition, leading to a minimization of symptoms. If substance use issues are present in the physician patient, the treating physician might be more likely to overlook or minimize them. If psychiatric illness is severe, the treating physician might have additional considerations when deciding if involuntary hospitalization is necessary. Thus, when treating another physician, it is important for the treating physician to acknowledge and recognize the potential loss of objectivity that can naturally arise. The treating physician should discuss the challenge of maintaining objectivity with the physician patient as a barrier to the therapeutic alliance.[4] The treating physician should give careful consideration if the physician patient is impaired, or if state medical board reporting is required, because this can have licensure, legal, practical, and emotional implications.[19,22]

Case vignette, continued. *The training director scheduled the first appointment for Dr. E, and he arrived 10 minutes late. During the first session, Dr. E admitted to Dr. A that he had been in numerous conflicts with other staff members at the university hospital where he was in his final year of training. Dr. E tended to minimize these arguments, often blaming the other individuals as the source of the conflict. He stated that these other people were being "too sensitive" or "too stupid to understand my instructions." He then told Dr. A that his training director required him to attend the therapy sessions, but he felt that therapy was a waste of his time. He explained to Dr. A that he had excelled in his psychiatry rotation training during medical school, but conceded that psychotherapy might help him learn more about the way his "brilliant and complex" mind worked. Dr. E ended by saying, "But I'm not sure if you are qualified to do that."*

"It sounds frustrating to feel forced to see me," Dr.

A responded. "Maybe together we can understand what has been happening in your life."

"Fine...I guess," the patient huffed.

PRACTICE POINT: Managing the narcissistic patient. Groves et al[1] describes "potentates" as patients who see themselves as important people and expect special treatment. Similar to VIPs and celebrities, these individuals can invoke powerful emotions within the treating physician. Unlike celebrities, potentates have no established appeal for publicity or social status. Furthermore, unlike with the other types of VIPs, treating physicians do not hold potentate VIPs in a higher regard than other patients. Potentates view themselves as being important, but the treating physician might view them as being no different from any other patient.

Patients with narcissistic personality disorder (NPD) might also consider themselves to be VIPs, even if the treating physician does not view them in this light. The fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) characterizes NPD by two core phenotypic personality traits: grandiosity and attention seeking. Problems with self- and interpersonal functioning are also often present in the patient with NPD.[2] Similar to other VIPs, patients with NPD might demand special treatment or request certain privileges in therapy.

Engaging in psychotherapy with a patient who has NPD can be challenging for the psychiatrist, especially when the patient treats the psychiatrist with disrespect. A potentate with NPD might treat his or her psychiatrist as an object instead of as a human being.[1] The potentate is also less inclined to accept the patient role and might present as unmotivated to address symptoms, as illustrated in the clinical case vignette.

Case vignette, continued. *At the next session, Dr. E briefly glanced around Dr. A's office, and with a frown and slight shake of his head stated, "Your desk is a mess, and your shirt has a coffee stain."*

"Ouch!" responded Dr. A. "I concede to having more things on my desk than I usually do. And thank you! I didn't even notice the coffee stain."

After a slight pause, she asked, "Is it hard to talk to someone who looks like they don't have it together?"

"Oh, I didn't mean anything by that," replied the patient. "Just pointing it out."

"What you said hurt my feelings, but only a little bit," said Dr. A. "I wonder if this happens in other areas of your life—you feeling like you're helping someone by pointing out a deficiency but instead you end up hurting them with your words?"

"I think you're being too sensitive, but yes. It's possible people are more touchy than I give them credit for," answered Dr. E.

PRACTICE POINT: Remain empathic, framing any devaluation imposed by the patient in a therapeutic context. Being prepared for this type of scenario with a potentate can be helpful for the psychiatrist. Once the therapeutic alliance has been established, bringing the devaluation of the psychiatrist and ambivalence about therapy to the patient's attention can be beneficial. An open discussion about the devaluation can help the potentate understand that the conflicts that occur outside of the psychiatrist's office are being re-created within the therapy. In the clinical case vignette, Dr. E devalued the psychiatrist in an attempt to feel superior and less anxious about his own deficits.

By maintaining a nonjudgmental and empathic approach toward the potentate with narcissistic traits, the psychiatrist can potentially protect the therapeutic alliance.[14] Furthermore, by modeling emotions that narcissists traditionally find intolerable, such as remorse and gratitude, the psychiatrist can create a less-threatening environment and demonstrate healthy coping skills.[15] Discussing these emotions can also potentially be therapeutic.[16,17]

CONCLUSION

Caring for the VIP creates unique and ethical challenges for the psychiatrist. However, understanding these challenges can help the psychiatrist navigate through the barriers to care created by the status of the VIP. Establishing a strong therapeutic alliance, maintaining professional boundaries, and treating the VIP like any other patient are important principles to consider. Reviewing best practice guidelines and seeking consultation with peers can be additionally helpful to the psychiatrist. Furthermore, as with other forms of psychotherapy, recognition and discussion of the emotions created by the transference and countertransference can prove to be therapeutic to the VIP.

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